



\*\*\*FOR OFFICE USE ONLY\*\*\*

Receipt #

ID #

Issue Date

License #

**Rhode Island  
Board of Medical Licensure and Discipline**

Room 205  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and  
License Application for:***

- ☐ Allopathic Medicine
- ☐ Osteopathic Medicine
- ☐ Academic Faculty  
(Limited Medical Registration)

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*Applicant - Print Name (First/MI/Last)*

- ☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

**Phone: (401) 222-3855**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-2158**

Revised 12/14/2004 awp

# GENERAL INFORMATION

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## **Enclosures**

The following materials and information should be enclosed within this application packet:

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## **Licensure Requirements**

### **U.S./Canadian Graduates**

- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of internship or residency by the Accreditation Council for Graduate Medical Education, Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

### **Foreign Graduates**

- Successfully completed a course of study from a medical school located outside the United States which is recognized by the World Health Organization.
- Obtained ECFMG certification.
- Have attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the State Board for Medicine.
- Have satisfactorily completed three (3) years of internship or residency in a training program accredited by the Accreditation Council for Graduate Medical Education.
- Have satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

## Licensure Requirements (Continued)

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### Academic Faculty - Limited Medical Registration

Academic Faculty - Limited Medical Registration Applicants **MUST**:

- be recommended by the Medical School Dean.
- be appointed to Senior Rank at the Medical School.
- renew yearly and reapply every five (5) years.
- practice **ONLY** in hospitals and facilities affiliated with the Medical School.

### Rules and Regulations

The rules and regulations governing the Practice of Medicine can be obtained at the following web site:

[http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD\\_2961.pdf](http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_2961.pdf)

Limited Medical Registration: [http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD\\_3194.pdf](http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_3194.pdf)

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure <http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm>

Controlled Substances Act <http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm>



# APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application and a separate FCVS application.

## **FCVS Application Process**

To have your "core" credentials verified, you must submit an FCVS application directly to the Federation's national office (Texas). This application must be obtained by contacting the Federation toll free at **1-888-ASKFCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:

<http://www.fsmb.org>

This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the Board. Because the verification process is the most time consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education (including Fifth Pathway)
- Postgraduate Training
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS will forward directly to the Board a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials. For more information about the FCVS process, or if you need assistance completing the FCVS application, call the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287).

## **Board Application Process**

In addition to the FCVS application and verification process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review and issuance of a license. So that we can move the process along more quickly, if you are an endorsement candidate and hold an active, unencumbered license in another state, your application materials will be presented to the Board and a license may be issued prior to our receiving the FCVS application. If we thereafter identify any problems with your FCVS application, your license will be voided. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact Lauren Dixon at (401) 222-7887, or by email at [LaurenD@doh.state.ri.us](mailto:LaurenD@doh.state.ri.us).

# INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

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Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

## **General Instructions**

1. Make a copy of the application and forms before you begin, in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to the Board.
5. **It is your responsibility to check on the status of your application.**

## **Completing your Board Application**

1. Complete the Board Application pages (7-14). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of \$437.50 (or \$537.50 if you are applying for your Controlled Substances Registration (CSR)), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the application. These application fees are **NON-REFUNDABLE**. If you are applying for your CSR, you **MUST** submit the Board application at the **SAME TIME** as the CSR application.

NOTE: These are Board Application Fees. The FCVS verification fee is an additional and separate fee paid directly to the FCVS.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 19). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

Rhode Island Department of Health  
Board of Medical Licensure & Discipline  
Room 205, Three Capitol Hill  
Providence, RI 02908-5097

## **Physician-Initiated Requests**

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail the Reciprocity Release Form (page 21) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
2. Be certain to sign and complete the identifying information on each form. **The Board must receive the verification(s) directly from the licensing authority.** Make copies of the form as needed. You may obtain

## INSTRUCTIONS (continued)

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the mailing address of all 69 U.S. medical and osteopathic licensing authorities at the Federation of State Medical Boards' web site at <http://www.fsmb.org> or by calling the Board in question. Please do not contact the Rhode Island Medical Board for mailing addresses of licensing authorities.

3. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a Practitioner Request for Information Disclosure, which can be obtained by calling the NPDB, or downloading it from the NPDB web site.

Phone Number for NPDB Information:  
NPDB web site:

1-800-767-6732  
<http://www.npdb-hipdb.com>

You must mail this completed form directly to NPDB. **When you receive a response, send the Board the ORIGINAL, UNOPENED** response. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

4. Obtain a total of four **(4) references** attesting to your character and professional abilities. To obtain this verification, mail the enclosed **Reference Form** to each the following:

- Chief of Staff in the hospital where you currently hold staff privileges;
- Hospital Administrator in the hospital where you currently hold staff privileges;
- Two (2) additional practicing physicians.

If you do not currently hold staff privileges, mail the Reference Form (page 22) to each the following:

- Chairman of the department where you had your major training;
- Director of Residency or Fellowship Training Program;
- Two (2) additional practicing physicians.

Letters or other forms submitted in lieu of the Reference Form will not be accepted. **The Board must receive these forms directly from the reference source.** Make copies of the form as needed.

5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.

6. In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.**

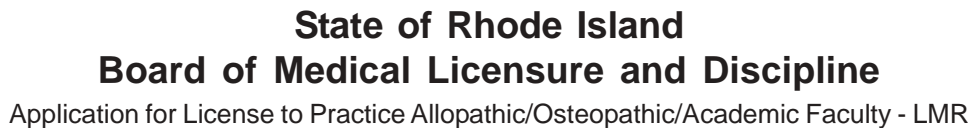
The Rhode Island CSR Application is available on page 20. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: [http://www.deadiversion.usdoj.gov/drugreg/reg\\_apps/](http://www.deadiversion.usdoj.gov/drugreg/reg_apps/)

The application process is not considered complete until your Board application, applicable forms and FCVS Physician Information Profile are received in a manner satisfactory to the Board. Neither the Board nor FCVS will accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for your wallet size license card to be mailed to you. [NOTE: You may not practice medicine in Rhode Island until you have received a license number.]

### **Special Notice about Malpractice Information**

In Section 17, "**Malpractice**":

Pursuant to R.I.G.L. § 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past 10 years. The Board will not make actual settlement or verdict amounts available to the public. It must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.



**1. Name(s)**

**All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.**

## 2. Social Security Number

**Please Refer to “Mandatory Addendum to License Application” on the last page of this application**

### 3. Gender

☐ Male ☐ Female

#### 4. Date and Place of Birth

		1	9																										
Month	Day	Year																											

City and State: **OR** Province and Country, etc., if NOT U.S.

## 5. Home Address

1st Line Address (Apartment/Suite/Room Number, etc.)																													
Second Line Address (Number and Street)																													
																						-							
City															State		Zip Code												
Country, If <u>NOT</u> U.S.																													
Home Phone																													
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																													

## 6. Primary Business Address

***This address will appear on the Department of Health web site.***

[illegible]

<b>7. Preferred Mailing Address</b> Please check <u>ONE</u>	<input type="checkbox"/> Please use my <b>Home Address</b> as my preferred mailing address  <input type="checkbox"/> Please use my <b>Business Address</b> as my preferred mailing address
<b>8. Specialty of Practice</b>  See ABMS Specialty Code List (pages 16-18).  <b>DOCUMENTATION:</b>  You must provide a notarized copy of your ABMS certificate(s).  You may report "None", "Other" or "Unknown" if necessary	<div style="display: flex; justify-content: space-between;"> <div> <input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/> </div> <div>           Board Certified?: <input type="checkbox"/> Yes <input type="checkbox"/> No         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Primary Specialty Code</div> <div>           If Yes, Year Certified/Recertified: <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/> </div> </div>
	<div style="display: flex; justify-content: space-between;"> <div> <input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/> </div> <div>           Board Certified?: <input type="checkbox"/> Yes <input type="checkbox"/> No         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Secondary Specialty Code</div> <div>           If Yes, Year Certified/Recertified: <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/> </div> </div>
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<b>9. Practice Information</b>  A. Specify where in this State you intend to practice, and list type of practice.  ACD = Academia ADM = Administration FTY = Facility FEL = Fellowship GRP = Group HSP = Hospital HMO = HMO OFC = Office RES = Research OTH = Other  B. Identify any translational services that may be available at your primary practice location	<div style="display: flex; justify-content: space-between;"> <div> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> </div> <div> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Location #1</div> <div>Practice Type (See Codes)</div> </div>
	<div style="display: flex; justify-content: space-between;"> <div> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> </div> <div> <input style="width: 60px; height: 20px; border: 1px solid black;" type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Location #2</div> <div>Practice Type (See Codes)</div> </div>
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If necessary, continue on a separate 8 1/2 X 11 sheet of paper.	
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<b>10. Practice History</b>  10A. Postgraduate Training History (Medical School to present)  <b>INSTRUCTIONS:</b> Graduates of US Medical Schools require 2 years of Postgraduate training and International Graduates require 3 years of postgraduate training. Internship experience can account for a maximum of 1 year of credit towards this requirement. See Rules and Regulations R5-37 Sect. 3.1. Explain gaps on separate 8 1/2 X 11 sheet of paper	<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Month</span><span>Year</span> </div> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> </div> <div> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Month</span><span>Year</span> </div> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> </div> </div>
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	Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
<div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div> <div style="border-bottom: 1px solid black; height: 20px; width: 100%;"></div>	

## 10. Practice History (Continued)

### 10B. Post-training Work History

Account for each year of post-training work activity from medical school through the present.

Explain gaps on separate 8 1/2 X 11 sheet of paper

Month	Year	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.

### 10C. Medical School Faculty Appointments

Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.

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## 11. Medical Licensure

List all states or countries in which you are now, or ever have been licensed to practice medicine, or any other profession.

State/Country:

<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive

State/Country:

<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
<input type="text"/>	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive



**DOCUMENTATION:** Send a Reciprocity Release Form to each entity. (See page 21)

## 12. Board Discipline

List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):

Type of Discipline:

	Month	Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials.

### 13. Hospital Privileges

List the name and address of **all** hospitals where you have ever held any type of privileges (e.g., courtesy, admitting, etc.).

<div></div>	<div></div>	—	<div></div>	<div></div>													
Month	Year		Month	Year	Type of Privileges												
<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>
Name of Hospital																	
<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>
City									<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	
									State	Zip/Postal Code							

Month	Year	—	Month	Year	Type of Privileges _____
<div style="border-bottom: 1px solid black; height: 20px;"></div>					
Name of Hospital _____ <div style="border-bottom: 1px solid black; height: 20px;"></div>					
City _____					State <div style="border-bottom: 1px solid black; width: 40px; float: right;"></div>
					Zip/Postal Code <div style="border-bottom: 1px solid black; width: 80px; float: right;"></div> — <div style="border-bottom: 1px solid black; width: 40px; float: right;"></div>

Month	Year	—	Month	Year	Type of Privileges
<div>Name of Hospital</div>					
City	State	—	Zip/Postal Code		

Month	Year	—	Month	Year	Type of Privileges
Name of Hospital					
City			State		Zip/Postal Code

<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>																							
Month	Year		Month	Year	Type of Privileges																						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
Name of Hospital																											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
City															<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
															State		Zip/Postal Code					—		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>																					
Month	Year		Month	Year	Type of Privileges																				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Name of Hospital																									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
City															<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
															State	Zip/Postal Code									

Month	Year	—	Month	Year	Type of Privileges
Name of Hospital					
City					State
					Zip/Postal Code

Month	Year	Month	Year	Type of Privileges
Name of Hospital				
City	State	Zip/Postal Code		

### 14. Hospital Discipline

Please explain any disciplinary actions and attach any relevant supplemental materials.  
List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded.

Also report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of the investigation.

☐ Check here if not applicable

Month	Day	Year	Type of Action
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
Name of Hospital			
Month	Day	Year	Type of Action
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
Name of Hospital			
Month	Day	Year	Type of Action
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
Name of Hospital			
Month	Day	Year	Type of Action
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
Name of Hospital			

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

### 15. Malpractice

Report all medical malpractice court judgments, medical malpractice arbitration awards and settlements in which payment was awarded or made to a complaining party since September 1, 1988 in any state in which you have held an active license since September 1, 1988. **Be certain to read and initial the statement at the bottom of this section.**

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Month	Day	Year	Amount Paid	Basis for Complaint
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>		
Month	Day	Year	Amount Paid	Basis for Complaint
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>		
Month	Day	Year	Amount Paid	Basis for Complaint
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>		
Month	Day	Year	Amount Paid	Basis for Complaint
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>		
Month	Day	Year	Amount Paid	Basis for Complaint
<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>		

I certify that I have read and understand the information provided on page 6 "Special Notice about Malpractice Information"

Initials

### 16. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>
	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>
	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>

<sup>1</sup>For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.



## 17. Questions

Check either Yes or No for each question.

**NOTE:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.



- |    |   |                              |                             |
|----|---|------------------------------|-----------------------------|
| 1. | During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | During any postgraduate training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | During any postgraduate training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Are there any charges or investigations pending, in any state, against you?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Note:** If you answered “yes” to any of these questions you must explain below or, if needed, on a separate sheet of paper.

**18. Physician Honors and Peer-Reviewed Publications (Optional)**

List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the most recent 10 years.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Awards, Honors:

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Publications:

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**19. Professional and Community Memberships (Optional)**

List any professional and community memberships.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Professional and Community Memberships:

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## 20. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Medical Licensure and Discipline any information which is material to my application for licensure.

I have read carefully both the statute (RIGL 5-37) and associated Regulations (R5-37 Reg.) for the licensure and discipline of physicians in Rhode Island. Further, I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I knowingly furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Rhode Island.

I understand that relevant portions of my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Medical Licensure and Discipline of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

**The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.**

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

Notary Seal

\_\_\_\_\_  
Notary No/Commission No.

\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)

## 21. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



**Write your name on the back of the photograph, and provide the date that the photograph was taken.**

\_\_\_\_\_  
Date of Photograph



## State of Rhode Island and Providence Plantations Department of Health

This information is completely voluntary and will NOT affect your Application in any way.

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### **VOLUNTARY RACE/ETHNICITY QUESTIONS\***

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Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

**1. Ethnicity:** Are you Hispanic or Latino? (Mark “No” if **not** Hispanic or Latino.)

☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino

**2. Race:** What is your race? (Mark one or more.)

☐ American Indian or Alaska Native ☐ Black or African American ☐ White  
☐ Asian ☐ Native Hawaiian or other Pacific Islander

For the purposes of the above questions kindly use the “Federal Minimum Data Collection” explanations listed below:

#### ***1. Ethnic Categories:***

##### **Hispanic or Latino**

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin” can be used in addition to “Hispanic or Latino.”

##### **Not Hispanic or Latino**

A person who is not Hispanic or Latino.

#### ***2. Racial Categories:***

##### **American Indian or Alaskan Native**

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

##### **Asian**

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

##### **Black or African American**

A person having origins in any of the Black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”.

##### **Native Hawaiian or Other Pacific Islander**

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

##### **White**

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

\*This information is being collected in accordance with the Department of Health’s Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

# ABMS Certification Codes

American Board	Code	General Certificate	Code	Subspecialty Certificates
Allergy & Immunology	<b>A &amp; I</b>	Allergy & Immunology	<b>CLI</b> <b>DLI</b>	Clinical & Laboratory Immunology Diagnostic Laboratory Immunology
Anesthesiology	<b>Anes</b>	Anesthesiology	<b>CCM</b> <b>PM</b>	Critical Care Medicine Pain Management
Colon & Rectal Surgery	<b>CRS</b>	Colon & Rectal Surgery		
Dermatology	<b>D</b>	Dermatology	<b>CLDI</b> <b>DI</b> <b>DP</b>	Clinical & Laboratory Dermatological Immunology Dermatological Immunology Dermatopathology
Emergency Medicine	<b>EM</b>	Emergency Medicine	<b>MT</b> <b>PEM</b> <b>SM</b>	Medical Toxicology Pediatric Emergency Medicine Sports Medicine
Family Practice	<b>FP</b>	Family Practice	<b>Ger</b> <b>SM</b>	Geriatric Medicine Sports Medicine
Internal Medicine	<b>IM</b> <b>AI</b>	Internal Medicine Allergy & Immunology	<b>AM</b> <b>CE</b> <b>CCEP</b> <b>CCM</b> <b>CLI</b> <b>Cv</b> <b>DLI</b> <b>EDM</b> <b>En</b> <b>Ge</b> <b>Ger</b> <b>Hem</b> <b>IntvCd</b> <b>Inf</b> <b>Nep</b> <b>Onc</b> <b>Pul</b> <b>Rhu</b> <b>SM</b>	Adolescent Medicine Cardiac Electrophysiology Clinical Cardiac Electrophysiology Critical Care Medicine Clinical & Laboratory Immunology Cardiovascular Disease Diagnostic Laboratory Immunology Endocrinology, Diabetes & Metabolism Endocrinology Gastroenterology Geriatric Medicine Hematology Interventional Cardiology Infectious Disease Nephrology Medical Oncology Pulmonary Disease Rheumatology Sports Medicine
Medical Genetics	<b>MG CBCGn</b> <b>MG CBMG</b> <b>MG CcytG</b> <b>MG Cgen</b> <b>MG CMGn</b> <b>MG PhDMG</b>	Clinical Biochemical Genetics Clinical Biochemical/Molecular Genetics Clinical Cytogenetics Clinical Genetics (M.D.) Clinical Molecular Genetics Ph.D. Medical Genetics	<b>MGP</b>	Molecular Genetic Pathology
Neurological Surgery	<b>NS</b>	Neurological Surgery		
Nuclear Medicine	<b>NuM</b>	Nuclear Medicine		
Obstetrics & Gynecology	<b>ObG</b>	Obstetrics and Gynecology	<b>CCM</b> <b>GO</b> <b>MF</b> <b>RE</b>	Critical Care Medicine Gynecologic Oncology Maternal-Fetal Medicine Reproductive Endocrinology
Ophthalmology	<b>Oph</b>	Ophthalmology		
Orthopaedic Surgery	<b>OrS</b>	Orthopaedic Surgery	<b>HS</b>	Hand Surgery
Otolaryngology	<b>Oto</b>	Otolaryngology	<b>ON</b> <b>PO</b> <b>PSHN</b>	Otology/Neurotology Pediatric Otolaryngology Plastic Surgery within the Head/Neck
<b>Codes Continued on next Page →</b>				

## ABMS Certification Codes (Continued)

American Board	Code	General Certificate	Code	Subspecialty Certificates
Pathology	<b>Path AP/CP</b> <b>Path AP</b> <b>Path CP</b>	Anatomic & Clinical Pathology Anatomic Pathology Clinical Pathology	<b>BB</b> <b>BBTM</b> <b>ChemP</b> <b>CytoP</b> <b>DP</b> <b>Fpath</b> <b>Hem</b> <b>IP</b> <b>MMB</b> <b>MGP</b> <b>Npath</b> <b>PdP</b> <b>RIP</b>	Blood Banking Blood Banking Transfusion Medicine Chemical Pathology Cytopathology Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Molecular Genetic Pathology Neruopathology Pediatric Pathology Radioisotopic Pathology
Pediatrics	<b>Ped</b>	Pediatrics	<b>AI</b> <b>AM</b> <b>CCM</b> <b>Cd</b> <b>CLI</b> <b>DBP</b> <b>DLI</b> <b>En</b> <b>Ge</b> <b>HO</b> <b>Inf</b> <b>MT</b> <b>Ne</b> <b>NP</b> <b>ND</b> <b>PEM</b> <b>Pul</b> <b>Rhu</b> <b>SM</b>	Allergy & Immunology Adolescent Medicine Pediatric Critical Care Medicine Pediatric Cardiology Clinical & Laboratory Immunology Developmental-Behavioral Pediatrics Diagnostic Laboratory Immunology Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Medical Toxicology Pediatric Nephrology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Emergency Medicine Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports Medicine
Physical Medicine & Rehabilitation	<b>PMR</b>	Physical Medicine and Rehabilitation	<b>PM</b> <b>PedRM</b> <b>SCIinj</b>	Pain Management Pediatric Rehabilitation Medicine Spinal Cord Injury Medicine
Plastic Surgery	<b>PIS</b>	Plastic Surgery	<b>HS</b>	Hand Surgery
Preventive Medicine	<b>PrM AeroM</b> <b>PrM GPM</b> <b>PrM OM</b> <b>PrM PH</b> <b>PrM PHGPM</b>	Aerospace Medicine General Preventive Medicine Occupational medicine Public Health Public Health & General Preventative Medicine	<b>MT</b> <b>UM</b> <b>UHM</b>	Medical Toxicology Undersea Medicine Undersea & Hyperbaric Medicine
Psychiatry and Neurology	<b>ChiN</b>  <b>N</b> <b>Psyc</b>	Neurology with Special Qualifications in Child Neurology Neurology Psychiatry	<b>AdP</b> <b>ChAP</b> <b>ChiP</b> <b>C/NPh</b> <b>FPsy</b> <b>GPsyc</b> <b>ND</b> <b>PM</b>	Addiction Psychiatry Child and Adolescent Psychiatry Child Psychiatry Clinical Neurophysiology Forensic Psychiatry Geriatric Psychiatry Neurodevelopmental Disabilities Pain Management
Radiology	<b>Rad DR</b> <b>Rad DRnt</b> <b>Rad DRSCNR</b>  <b>Rad NM</b> <b>Rad R</b> <b>Rad Rnt</b> <b>Rad RO</b> <b>Rad RT</b> <b>Rad TO</b> <b>Rad TR</b>	Diagnostic Radiology Diagnostic Roentgenology Diagnostic Radiology with Special Competence in Nuclear Radiology Nuclear Medicine Radiology Roentgenology Radiation Oncology Radium Therapy Therapeutic Roentgenology Therapeutic Radiology	<b>NR</b> <b>NRad</b> <b>PR</b> <b>VIR</b>	Nuclear Radiology Neuroradiology Pediatric Radiology Vascular & Interventional Radiology
<b>Codes Continued on next Page→</b>				

## ABMS Certification Codes (Continued)

American Board	Code	General Certificate	Code	Subspecialty Certificates
Radiological Physics	<b>Rad DRMNP</b> <b>Rad DRP</b> <b>Rad MNP</b> <b>Rad RP</b> <b>Rad RRP</b> <b>Rad TDRP</b>  <b>Rad TRNP</b>  <b>Rad TRP</b> <b>Rad XRP</b>	Diagnostic Radiology & Medical Nuclear Physics Diagnostic Radiological Physics Medical Nuclear Physics Radiological Physics Roentgen Ray Physics Therapeutic & Diagnostic Radiological Physics  Therapeutic Radiology & Medical Nuclear Physics  Therapeutic Radiological Physics X-Ray & Radium Physics		
Surgery	<b>S</b>	Surgery	<b>VascS</b> <b>HS</b> <b>PdS</b> <b>SCC</b>	Vascular Surgery Hand Surgery Pediatric Surgery Surgical Critical Care
Thoracic Surgery	<b>TS</b>	Thoracic Surgery		
Urology	<b>U</b>	Urology		



# APPLICATION CHECKLIST

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Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

## **Board Application**

- ☐ I have read and understand the "Instructions for Completing the Board Application."
- ☐ I have carefully read RIGL 5-37 and R5-37REG available at:  
<http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm>  
[http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD\\_2961.pdf](http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_2961.pdf)
- ☐ I have completed the Rhode Island Board application as instructed (pages 7-14).
- ☐ I have completed Section 20, "**Affidavit of Applicant**" and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 21, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check or money order** made payable (in U.S. funds only) to the "**Rhode Island General Treasurer**" in the amount of **\$437.50** (or **\$537.50 with CSR application\***) and attached have it to the upper left-hand corner of the first (cover/top) page of the application.
- ☐ I have arranged my Board Application materials in following order:
  1. Fee (attached as instructed)
  2. Board Application (cover/top page, and pages 7-14)
  3. RI Uniform Controlled Substances Registration (CSR) (page 20, If Applicable)
  4. Supporting documentation as required. [Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
  5. Completed "Mandatory Addendum to License Application" - Verification of Social Security Number form
- ☐ I have mailed the above application materials directly to the Licensing Office, Department of Health.

## **Required Forms / Letters**

- ☐ I have completed and mailed the following forms as instructed:
  1. Reciprocity Release Form(s) (Licensure Verification)
  2. Practitioner Request for Information Disclosure (National Practitioner Data Bank)
  3. **Four (4)** Reference Forms

## **FCVS Application**

- ☐ I have completed the FCVS application, and submitted all required forms, documents, and fee directly to FCVS.

## **Controlled Substances Act Registration (CSR)**

**\*Note:** In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substances Act Registration (CSR)** and a **Drug Enforcement Administration (DEA) Registration**.

The Rhode Island CSR Application is available on page 20. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA:

DEA Phone Number: (617) 557-2200.  
DEA Web Site: [http://www.deadiversion.usdoj.gov/drugreg/reg\\_apps/](http://www.deadiversion.usdoj.gov/drugreg/reg_apps/)



## Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

### Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). I understand that this application **MUST** be submitted along with my Board Application. I also understand that there is an additional \$100.00 fee for this Registration and that the check or money order for **\$537.50 (NON-REFUNDABLE Board Application fee (\$437.50) PLUS CSR Application fee (\$100.00))** must be made out to the "RI General Treasurer".

Print/Type Full Name

Business Name

Signature

Business Address

Business Telephone

Date

Business Fax

<p>Complete this application for registration to prescribe controlled substances in the State of Rhode Island</p>	<p>The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: <a href="http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm">http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm</a></p>
<p>A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.</p> <p>The CSR is renewed at the same time that the professional license is renewed.</p> <p><b>NOTE:</b> Read Important Information on the bottom of this application.</p>	<p align="center"><b>Drug Schedule (Check all that apply)</b></p> <p><input type="checkbox"/> Schedule II    <input type="checkbox"/> Schedule III    <input type="checkbox"/> Schedule IV    <input type="checkbox"/> Schedule V</p> <p><b>A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA.</b> The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*</p> <p>All Applicants <b>MUST</b> answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <span style="float:right"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <span style="float:right"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p align="center"><b>If you answered "Yes" to question "A" or "B" attach an explanation to this form.</b></p>
<p align="center"><b>Important Information</b></p> <p>Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "<b>VOID</b>". Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.</p> <p>Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.</p> <p>A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: <a href="http://www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html">www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html</a></p> <p>*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.</p> <p align="center"><b>NOTE:</b></p> <ul style="list-style-type: none"> <li>- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.</li> <li>- Prescriptions in schedules III, IV and V cannot be written for more than one hundred (100) dosage units and not more than one hundred (100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.</li> <li>- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.</li> </ul>	



Substitute forms are not acceptable. This form may be duplicated as needed.

**Rhode Island Board of Medical Licensure and Discipline**  
Room 205, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-3855

## RECIPROCITY RELEASE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

License Number

Date Issued

### THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for issuing License:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX \_\_\_\_\_ State Sponsor ☐ State Exam \_\_\_\_\_ (State)

If a combination of exams were taken, please list the specific combination:

License Status:

☐ Active ☐ Inactive ☐ Lapsed

Original Date Issued:

Expiration Date:

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

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### Certification:

Signature

Date

Type or Print Name

Title

Full Name and of Licensing Board including State

Please Affix  
Board Seal Here

*Please return directly to the Board at the above address. Thank you for your prompt cooperation.*



Substitute forms are not acceptable. This form may be duplicated as needed.

## Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill  
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### REFERENCE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form be completed as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

### THIS SECTION TO BE COMPLETED BY THE INDIVIDUAL PROVIDING THE REFERENCE

**Please Note: References must be typed or printed clearly. Illegible references may delay a candidate's application**

#### EVALUATION

*Based upon demonstrated performance and composite of evaluations by supervisors on file.*

	Superior	Satisfactory	Unsatisfactory	No Information
Basic Clinical Knowledge				
Professional Judgement				
Clinical Competence and Skill				
Reliability/Sense of Responsibility				
Patient Management				
Ethical Conduct				
Physician-Patient Relationship				
Ability to Work with Other Hospital Staff				
Appearance				
Medical Recordkeeping				
Ability to Communicate Verbally				
<b>Recommendation:</b>	<b>OVERALL RATING:</b>			

☐ Recommended Highly without Reservation

☐ Recommended as Qualified and Competent

☐ Recommended with Reservation

☐ No Comment

☐ Not Recommended

**Additional Comments** (Use reverse side if necessary):

**You must affix your institution's official seal or have your signature notarized**

Printed Name of Reference

Signature

Title

Date

Relationship to Applicant

Please Affix  
Hospital or Notarial Seal  
Here

*Please return directly to the Board at the above address. Thank you for your prompt cooperation.*



*Substitute forms are not acceptable. This form may be duplicated as needed.*

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**ACADEMIC FACULTY - LIMITED MEDICAL REGISTRATION APPLICANTS ONLY**

I am applying for an Academic Faculty- Limited Medical Registration in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires these questions be answered as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name

Signature

Date

Previous Names Used

Social Security Number

Date of Birth

**THESE QUESTIONS ARE TO BE ANSWERED BY THE DEAN OF THE MEDICAL SCHOOL**

**Please Note: Information must be typed or printed clearly and submitted under separate cover.**

Please provide information pertaining to the following:

1. Describe this candidate's exceptional qualifications that warrant consideration for license as an Academic Faculty - Limited Medical Registration.
2. Describe fully the candidate's primary clinical and non-clinical activities.
3. Please state the anticipated faculty rank of the candidate.
4. Please describe the Formal Search/Recruitment efforts that led to the selection of this candidate including the number of candidates interviewed and duration of search.
5. Please describe system of academic supervision of candidate's clinical practice.



**State of Rhode Island and Providence Plantations**



**DEPARTMENT OF HEALTH**

Office of the Director

Cannon Building

3 Capitol Hill

Providence, RI 02908-5097

## **Mandatory Addendum to License Application**

Verification of Social Security Number/Federal Employer Identification  
Number and affidavit concerning taxpayer status

**Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.**

**I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number (SSN) or Federal  
Employer Identification Number (FEIN)

**Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.**

**This form MUST be completed, signed and attached to your license application in order for us to process your application.**